South Carolina State Budget and Control Board Employee Insurance Program Active Notice of Election (NOE)

ADM INFO

Check One: ☐ New Hire ☐ Transfer ☐ Change

Type of Change: ☐ Enrollment ☐ Other *(specify)* _____ ☐ Address Date of Occurrence: _____

BA Use Only
Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)*
Group ID#: _____
Group Name: _____

MoneyPlu$ ☐ Yes ☐ No
Health Savings Account ☐ Yes ☐ No *(For Use With Savings Plan)*

ENROLLEE INFO

1. Social Security Number	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY
_____-_____-_____					

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code Select One	18. Annual Salary	19. Date of Hire MM/DD/YYYY

MEDICARE

LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.

20. NAME	MEDICARE#	ELIGIBLE DUE TO	EFFECTIVE DATE PART A MM/DD/YYYY	EFFECTIVE DATE PART B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

COVERAGE

21. HEALTH PLAN *(Refuse or select one plan and one category)*

PLAN ☐Standard ☐HMO_____ *Name of HMO*
☐Refuse ☐Savings (Non-Medicare)

CATEGORY
☐Enrollee ☐Enrollee/Child(ren)
☐Enrollee/Spouse ☐Family

22. STATE DENTAL PLAN *(Select One)*
☐Refuse ☐Enrollee ☐Enrollee/Spouse ☐Enrollee/Child(ren) ☐Family

23. DENTAL PLUS *(Select One)*
☐Refuse ☐Yes

24. DEPENDENT LIFE - Child(ren) *(Select One)*
☐Refuse ☐$15,000

25. DEPENDENT LIFE - Spouse *(Select One)*
☐Refuse ☐Coverage Level
$_____
(Must be in increments of $10,000)

26. OPTIONAL LIFE *(Select One)*
☐Refuse ☐Coverage Level
$_____
(Must be in increments of $10,000)

27. SUPPLEMENTAL LTD *(Select One)*
☐Refuse
☐Plan One - *90-day benefit waiting period*
☐Plan Two - *180-day benefit waiting period*

28. BASIC LIFE/BASIC LTD
Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

BENEFICIARIES

In blocks 29, 30 and 31, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

Basic Life or Optional Life *(Check one or both)*	29. SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent
☐Basic Life ☐Optional Life						
☐Basic Life ☐Optional Life						

If Beneficiary is an organization or trust, complete the following:
Organization/Trust_____ Address_____ If Trust, Date Signed_____

DEPENDENTS

List spouse and eligible children to be covered. If they are not listed, they will not be covered. Is your spouse a state employee or retiree? ☐YES ☐NO

Add (A) or Delete (D)	30. Dependent SSN#	Last Name	First Name	SEX M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Status
	Spouse						Spouse employed by state-covered entity? ☐Yes ☐No
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated
	Child						☐Full-time student ☐Incapacitated

31. Does your dependent(s) have other health coverage? ☐YES ☐NO Does this coverage include pharmacy benefits? ☐YES ☐NO

If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing conditions, if applicable.

DEPENDENT NAME	INSURANCE COMPANY	POLICY HOLDER DATE OF BIRTH	EFFECTIVE DATE OF POLICY	TERMINATION DATE *(If Applicable)*

CERTIFICATION & AUTHORIZATION

32. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period (every two years) unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

33. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Date _____

EMPLOYEE INSURANCE PROGRAM INSTRUCTIONS FOR ACTIVE NOTICE OF ELECTION

IF COMPLETING BY HAND, USE BLACK INK

ADMINISTRATIVE INFORMATION: Indicate type of action to be taken. MONEYPLU$: Premiums for health/dental and Optional Life are deducted on a pretax basis. There is an administrative fee for the pretax deductions. MoneyPlu$ changes are limited by IRS restrictions and must be made during enrollment or within 31 days of the date of occurrence of a qualifying change in family status. HEALTH SAVINGS ACCOUNT: To be used with Savings Plan and is governed by IRS regulations.

ENROLLEE INFORMATION: Blocks 1-19 must be completed for all transactions, including a refusal.

MEDICARE: Block 20. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

COVERAGE: Alterations in this section are not allowed.

Block 21. HEALTH: Before making a health plan selection, refer to the plan descriptions provided by your employer.

To decline health coverage, check "Refuse." If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can apply for coverage for yourself and/or your dependent(s) only during an open enrollment period (every two years). If health coverage is refused, benefits for Basic Life and Basic LTD are forfeited.

To select a health plan, check only one block.

To select a category, check only one block. For dependent(s) to be covered, they must be listed in Block 30, and the appropriate category must be selected.

Block 22. DENTAL: To decline dental coverage, check "Refuse." If you refuse dental now, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period (every two years).

To select coverage, check only one block. For dependents to be covered, they must be listed in Block 30, and the appropriate category must be selected.

Block 23. DENTAL PLUS: To select Dental Plus coverage, check "Yes;" to refuse coverage, select "Refuse." You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

Block 24. DEPENDENT LIFE—CHILD(REN): To decline or cancel coverage, check "Refuse." To select coverage, check block. For dependents to be covered, they must be listed in Block 30.

Block 25. DEPENDENT LIFE—SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer.

To decline or cancel coverage, check "Refuse." To select coverage, check block and enter coverage level for your spouse based on your current level of Optional Life and/or approved medical evidence of good health. For your spouse to be covered, he/she must be listed in Block 30.

Block 26. OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer.

To decline coverage or cancel coverage, check "Refuse." To select coverage, check block and enter coverage level. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus pretax premium feature, you must wait until the next enrollment period or within 31 days of a special eligibility situation.

Block 27. SUPPLEMENTAL LONG TERM DISABILITY: Before making a selection, refer to the detailed instructions provided by your employer.

To decline coverage or cancel coverage, check "Refuse." To select coverage, check only one block. If changing from "Plan Two" to "Plan One," medical evidence of good health must be provided.

Block 28. BASIC LIFE AND BASIC LTD: Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

BENEFICIARIES: Block 29. List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a given name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

DEPENDENTS: Block 30. If you select a category with spouse/dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if not a state employee. A state employee is defined as an employee of a state agency, public school district, county, municipality, local subdivision or other entity participating in the State of South Carolina Insurance Benefits Program. If spouse is a state employee or is employed at a state-covered entity, check "Yes." Legal documentation is required for all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister, adopted child). For a child age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student or incapacitated. (Documentation required for both.) Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

Block 31. If you checked "Yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "No" and list the termination date of the policy.

CERTIFICATION AND AUTHORIZATION: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

Benefits Administrator must sign and date form and attach all supporting documentation before submitting it to the Employee Insurance Program at P.O. Box 11661 Columbia, SC 29211-1661.